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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **DEBORAH CAROLINE HAINES** **2525 South 29th Drive** **Yuma, AZ 85364** **Registered Nurse License No. 687532** Respondent.	Case No. 2012-45 **A C C U S A T I O N**

Louise R. Bailey, M.Ed., RN ("Complainant") alleges:

PARTIES

1. Complainant brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing ("Board"), Department of Consumer Affairs.

2. On or about August 25, 2006, the Board issued Registered Nurse License Number 687532 ("license") to Deborah Caroline Haines ("Respondent"). The license was in full force and effect at all times relevant to the charges brought herein and will expire on July 31, 2012, unless renewed.

JURISDICTION

3. Business and Professions Code ("Code") section 2750 provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive

license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

4. Code section 2764 provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under Code section 2811(b), the Board may renew an expired license at any time within eight years after the expiration.

STATUTORY PROVISIONS

5. Code section 2761 states, in pertinent part:

> The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for the following:
>
> (a) Unprofessional conduct.
>
> (4) Denial of licensure, revocation, suspension, restriction, or any other disciplinary action against a health care professional license or certificate by another state or territory of the United States, by any other government agency, or by another California health care professional licensing board. A certified copy of the decision or judgment shall be conclusive evidence of that action.

COST RECOVERY

6. Code section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

FIRST CAUSE FOR DISCIPLINE

(Out-of-State Discipline)

7. Respondent is subject to discipline under Code section 2761(a)(4), in that effective January 3, 2011, pursuant to an Order issued by the Arizona State Board of Nursing, in a disciplinary proceeding titled, *In the Matter of Registered Nurse License No. RN114470 Issued to Deborah C. Haines*, Respondent's registered nursing license number RN114470, was revoked. The Order was based on numerous Findings of Fact and Conclusion of Law, including the following: 1) Respondent failed to maintain minimum standards of acceptable and prevailing nursing practice; 2) Respondent failed to maintain a patient record that accurately reflected the

nursing assessment, care, treatment, and other nursing services provided to that patient; 3) Respondent practiced in a manner that gave the Board reasonable cause to believe the health of a patient or the public may be harmed; 4) Respondent made a false or misleading statement on a nursing or health care related employment or credential application concerning previous employment, employment experience, education, or credentials; 5) Respondent demonstrated unprofessional conduct that included being mentally incompetent or physically unsafe to a degree that is or might be harmful or dangerous to the health of a patient or the public; and 6) Respondent demonstrated a pattern of using or being under the influence of alcohol, drugs, or a similar substance to the extent that her judgment may have been impaired and nursing practice detrimentally affected, or while on duty in any health care facility, school, institution, or other work location. The Findings of Fact and Conclusion of Law, and Order is attached hereto as **Exhibit A** and incorporated herein by reference.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 687532, issued to Deborah Caroline Haines;

2. Ordering Deborah Caroline Haines to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Code section 125.3; and,

3. Taking such other and further action as deemed necessary and proper.

DATED: July 21, 2011

LOUISE R. BAILEY, M.ED., RN
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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Exhibit A
Findings of Fact, Conclusions of Law and Order

ARIZONA STATE BOARD OF NURSING
4747 North 7th Street Ste 200
Phoenix AZ 85014-3655
602-771-7800

IN THE MATTER OF REGISTERED NURSE LICENSE NO. RN114470 ISSUED TO: **DEBORAH C. HAINES,** Respondent.	**FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER NO. 10A-0912145-NUR and 09A-0706019-NUR**

A hearing was held before Diane Mihalsky, Administrative Law Judge, at 1400 West Washington Suite 101, Phoenix Arizona, on October 27, 2010. Emma Lehner Mamaluy, Assistant Attorney General, appeared on behalf of the State. Deborah C. Haines ("Respondent") was not present and was not represented by counsel.

On November 10, 2010, the Administrative Law Judge issued Findings of Fact, Conclusions of Law and Recommendations. On November 29, 2010, the Arizona State Board of Nursing met to consider the Administrative Law Judge's recommendations. Based upon the Administrative Law Judge's recommendations and the administrative record in this matter, the Board makes the following Findings of Fact and Conclusions of Law.

FINDINGS OF FACT

1. The Arizona State Board of Nursing ("the Board") has the authority to regulate and control the practice of nursing in the State of Arizona, pursuant to A.R.S. §§ 32-1606, 1663, and 1664. The Board also has the authority to impose disciplinary sanctions against the holders of nursing licenses for violations of the Nurse Practice Act, A.R.S. §§ 32-1601 through 1667.

2. Respondent holds Board-issued Registered Nurse License Number RN114470 in the State of Arizona.

3. On June 11, 2007, the Board received a complaint from Claudette C. Rodstrom, R.N., M.S.N., Director of Med West, Yuma Regional Medical Center ("YRMC"), in Yuma, Arizona. The complaint alleged that while Respondent worked at YRMC, she failed to meet the standard of care in several areas and that as a result, YRMC terminated her employment.

4. The Board designated Ms. Rodstrom's complaint as Case No. 09-0706019 and opened an investigation.

5. On March 25, 2009, the Board voted to offer Respondent a consent agreement to resolve the complaint in Case No. 09-0706019. The proposed consent agreement required, among other things, that Respondent undergo a psychological evaluation and consent to work under the supervision of a practice monitor.

6. Respondent rejected the Board's proposed consent agreement. On June 24, 2009, the Board issued a Notice of Charges in Case No. 09-0706019.

7. On or about December 16, 2009, the Board received a second complaint from an anonymous complainant at Maricopa Integrated Health Systems ("MIHS") in Phoenix, Arizona. The complaint alleged that on December 11, 2009, Respondent was admitted to MIHS for a court-ordered psychiatric evaluation, after shooting herself in the head and being medically cleared.

8. The Board designated the anonymous complaint from MIHS as Case No. 10-0912145 and opened an investigation.

9. In Case No. 10-0912145, the Board offered to allow Respondent to voluntarily suspend her license to allow the Board to determine her safety to practice. On September 22, 2010, after Respondent failed to respond to the Board's offer, it determined that the public health, safety, and welfare imperatively required emergency action and summarily suspended Respondent's license.

10. On September 23, 2010, the Board issued a Complaint and Notice of Hearing, and on September 28, 2010, the Board issued an Amended Complaint and Notice of Hearing, setting an evidentiary hearing on October 27, 2010, in the Office of Administrative Hearings, an independent agency.

11. The Amended Complaint and Notice of Hearing alleged that cause existed to discipline Respondent's registered nurse license under A.R.S. §§ 32-1663(D), 32-1664(N), 32-1601(16)(d), and 32-1601(16)(j) (namely A.A.C. R4-19-403(B)(1), (7), (17), (27) and (31)).

12. A hearing was held on October 27, 2010. The Board presented the testimony of six witnesses: (1) Ms. Rodstrom, the complainant in Case No. 09-0706019 and Respondent's former supervisor at the Med West unit at YRMC; (2) Valerie Smith, R.N., M.S.N., the Board's associate director and an expert on the applicable standard of care and on the potential effect of substance abuse and mental illness on a nurse's practice; (3) Deborah Richards, J.D., the Board's senior investigator; (4) Officer Pete Olea of the Yuma Police Department ("YPD"), who investigated Respondent's apparent suicide attempt; (5) Michael Vines, M.D., the psychiatrist who evaluated Respondent and supervised Respondent's treatment at Superstition Mountain Mental Health Center ("SMMHC") in Yuma; and (6) Angela Hill, R.N., the Board's nurse consultant who conducted the Board's investigation in Case No. 10-0912145.

13. The Board also submitted 24 exhibits, including copies of signed United States Postal Service receipts to establish delivery of the various notices that the Board had sent via certified mail to Respondent at her address of record in Yuma, as follows: (1) On September 17, 2010, one Alma R. Carpenter signed the receipt for the Board's Notice of Board Consideration and the State's Motion for Summary Suspension; (2) On October 6, 2010, Respondent signed the receipt for the Board's Findings of Public Emergency and Order of Summary Suspension; (3) On October 6, 2010, Respondent signed

the receipt for the Board's Complaint and Notice of Hearing; and (4) On October 6, 2010, Respondent signed the receipt for the Board's Amended Complaint and Notice of Hearing.

14. Although the beginning of the hearing was delayed thirty minutes to allow Respondent additional travel time, she did not appear, personally or through an attorney, or contact the Office of Administrative Hearings to request a continuance or that the start of the hearing be further delayed. Complainant did not present any evidence to defend her license.

HEARING EVIDENCE

Case No. 09-0706019

15. From September 5, 2006, to June 7, 2007, Respondent was employed as a registered nurse at YRMC.

16. Ms. Rodstrom testified that Respondent initially was assigned to the medical surgical unit, where she was "not doing well." On October 1, 2006, Respondent transferred into Ms. Rodstrom's unit, Med West. On October 17 or 18, 2006, and on November 1, 2006, Ms. Rodstrom counseled Respondent about various patient care issues.

17. Ms. Rodstrom testified that Respondent's communication style was also an issue. Respondent was condescending, sarcastic, and blamed others for her mistakes.

18. On January 25, 2007, YRMC issued a formal reminder to Respondent for her care of two patients, as follows.

18.1 Patient MR#931357. On January 10, 2007, Respondent failed to administer 1 unit of blood as ordered. Although the order was written at 6:00 a.m., Respondent failed to obtain consent for blood administration. Respondent also failed to transcribe orders to discontinue Levaquin and start Cefipime into the Medication Administration Record ("MAR"). Respondent also did not start the Cefipime, start magnesium sulfate as ordered, change the PICC line dressing per protocol, or inform the

attending physician or resource coordinator that the patient could not have a lumbar puncture due to positive blood cultures.

18.2 Patient MR#0888049. On January 10, 2007, Respondent failed to document the neurological assessment required on admission. Respondent administered Lisinopril 40 mg., even though this patient's heart rate was 56. Telemetry documented sinus bradycardia with a rate in the 40's.

19. Ms. Rodstrom testified that discontinuation of the antibiotic Levaquin indicated that it was not effectively treating Patient MR#931357's infection. Respondent's failures to discontinue the Levaquin, to start the antibiotic Cefipime, and to inform the physician that the patient had a positive blood culture could have caused the patient to go into septic shock.

20. Ms. Rodstrom testified that a PICC line is inserted in a larger vein to administer medication intravenously. If the dressing is not kept clean, the patient could get an infection.

21. Ms. Rodstrom testified that a nurse is responsible for monitoring a patient who has been prescribed medication to lower blood pressure, such as Lisinopril, to ensure that the patient remains stable. Before administering medication to lower blood pressure, the nurse must measure the patient's blood pressure and heart rate, make sure the patient is alert and oriented, and explain to the patient that because the medication will reduce blood flow to the brain, the patient may become faint or fall. Ms. Rodstrom testified that if the patient's blood pressure or heart rate is already low, for patient safety the nurse should consult the physician or pharmacist before she administers medication that will further lower blood pressure.

22. Ms. Rodstrom testified that when she met with Respondent to discuss the formal reminder, Respondent "did not say much," became defensive, and attempted to blame others.

Respondent nonetheless signed the January 25, 2007 reminder to indicate that she had received it, and informed Ms. Rodstrom that she would try to do better. Respondent did not appeal the reminder.

23. Respondent worked another six 12-hour shifts in February 2007, and then took medical leave from YRMC until February 27, 2007. On March 7, 2007, the health nurse informed YRMC that Respondent's shifts needed to be reduced to 8 hours. Ms. Rodstrom continued to monitor Respondent's care of patients. Ms. Rodstrom testified that normally she trusts nurses to do their jobs, and that she has never before exercised the level of supervision that she exercised over Respondent.

24. On March 26, 2007, Respondent was given a Corrective Action Plan and was placed on decision-making leave for issues related to her care of four patients, as follows.

24.1 Patient MR#0787222. On February 10, 2007, Respondent noted orders for potassium chloride and magnesium sulfate at 12:00 p.m., but failed to document administering the medications on the MAR.

24.2 Patient MR#0753450. On February 17, 2007, Respondent received an order to decrease Prednisone to 20 mg. orally once daily. The patient had not previously been ordered Prednisone. Respondent failed to clarify the unclear order with the physician and did not administer any Prednisone to the patient. Respondent also failed to accurately calculate the patient's pressure ulcer risk score.

24.3 Patient MR#0933811. On February 18, 2007, Respondent failed to administer Zosyn pursuant to an order that was processed at 10:00 a.m. The order required doses at 12:00 p.m. and 7:00 p.m., but the doses were not charted on the MAR as given, even though the order was called to Respondent's attention at approximately 2:00 p.m.

24.4 Patient MR#0715640. On February 18, 2007, Respondent administered blood pressure lowering medication, even though the patient's blood pressure was already low at 90/52, and the attending physician had issued an order to hold all blood pressure medications.

25. Ms. Rodstrom testified that magnesium sulfate and potassium chloride were electrolytes for heart function. Respondent's failure to administer the drugs could have caused cardiac arrest and deviated from the standard of care.

26. Ms. Rodstrom testified that Respondent's failure to clarify an unclear order with the physician deviated from the standard of care.

27. Ms. Rodstrom testified that the Braden scale is an evidence-based scale and the standard of care to identify patients who are at high risk for skin breakdown. The Braden scale assigns a numerical value to numerous factors, such as the patient's prescribed medications, nutrition, activity, age, and diagnoses. Respondent's failure to accurately calculate the patient's pressure ulcer risk score deviated from the standard of care.

28. Ms. Rodstrom testified that a patient who has been prescribed the antibiotic Zosyn has an infection and is septic. Respondent failed to administer two doses of an IV antibiotic that the doctor had prescribed to be administered every six hours. The 12-hour delay in the administration of Zosyn potentially could have caused the patient to go into septic shock, and deviated from the standard of care.

29. Ms. Rodstrom testified that Respondent's errors were basic and involved practice areas that even student nurses know. Ms. Rodstrom testified that Respondent was given a day of decision-making leave "to reflect on whether she wanted to continue" her employment as a nurse at YRMC.

30. On March 28, 2007, Respondent signed the Corrective Action Plan, indicating that she understood YRMC's expectations regarding professional communication with her co-workers, expectations regarding the expected standard of care, and the consequences of not meeting those expectations.

31. On March 28, 2007, as part of the Corrective Action Plan, Respondent wrote and submitted to Ms. Rodstrom a Written Contract for Professional Communications ("Written Contract") that included the following provisions:

- I will accept constructive criticism when delivered in a constructive manner.
- I will be very receptive to Resource Coordinators [sic] feedback when delivered in a constructive manner.
- I will continue to be a good listener.
- I am receptive to seeking improvement in constructive verbal and written communication skills from professional staff members who demonstrate the same.

32. Ms. Smith testified that the conditions that Respondent included in the Written Contract demonstrated that she did not "own" or accept responsibility for the communication and practice shortcomings that had made the Corrective Action Plan necessary.

33. Respondent was on medical leave until April 4, 2007, and then placed on light duty. Because the Med-West unit could not accommodate Respondent's need for light duty, she performed clerical work until May 23, 2007, when the medical nurse cleared her to return to nursing duties. On May 23, 2007, Ms. Rodstrom required Respondent to sign the Corrective Action Plan and Written Contract again to let her know that "nothing had gone away."

34. On May 24, 2007 at 2:45 p.m., while caring for Patient MR#0457464, Respondent wrote a verbal order in the MAR for Protonix 40 mg. IV every 12 hours with the first dose to be given STAT. The unit secretary noted the order at 3:00 p.m., and Respondent noted and signed off on the order at 3:10 p.m. The patient did not receive Protonix during Respondent's shift, and a member of the night shift found the Protonix in the medication room.

35. On May 24, 2007, a physician wrote certain orders for Patient MR0809223, including consent for "[d]ebridement, hardware removal and bone biopsy left ankle." Although the unit secretary

noted the orders at 2:00 p.m., Respondent did not note in the MAR that she received the orders, although she did obtain the patient's consent at 4:00 p.m.

36. Ms. Rodstrom testified that Protonix decreases stomach acid and prevents heartburn. Without the medication, the patient would have been uncomfortable and probably would have complained. Despite all the coaching and increased supervision, Respondent was not improving. Ms. Rodstrom could no longer support Respondent because of the probability that a patient would be harmed if Respondent continued her employment at YRMC.

37. On June 7, 2007, YRMC terminated Respondent's employment for failing to maintain the standard of nursing care expected at YRMC.

38. Ms. Rodstrom testified that when she met with Respondent on June 7, 2007, Respondent smelled of "old alcohol." Ms. Rodstrom testified that she does not believe that Respondent is safe to practice and believes that Respondent hurts her patients more than she helps them. Respondent is one of the worst nurses that Ms. Rodstrom has ever seen; she would not want Respondent looking after her or a family member.

39. Ms. Smith testified that YRMC took "extraordinary efforts" to coach Respondent and to remediate performance issues. Most employers under similar circumstances would have released Respondent long before YRMC did.

40. On June 13, 2007, the Board's staff informed Respondent of Ms. Rodstrom's complaint. On July 20, 2007, Respondent returned to the Board a completed Investigative Questionnaire, providing her response to Ms. Rodstrom's complaint in Case No. 09-0706019.

41. Respondent's completed Investigative Questionnaire claimed that she had been a victim of undeserved harassment at YRMC. Ms. Smith testified that Respondent's allegations were not credible in light of the evidence of Respondent's practice issues and knowledge deficits.

42. On or about December 28, 2007, Respondent submitted an application and employment profile to ANM O'Grady Peyton Healthcare in San Diego, California. Respondent answered "no" to the question in the application, "Has your license or certificate ever been investigated or suspended?". Respondent also stated that she voluntarily left YRMC for "improved pay/travel nursing."

43. The Board's nurse consultant, Sydney Munger, R.N., investigated Ms. Rodstrom's complaint and prepared an investigative report.[1] According to Ms. Munger's report, on February 11, 2009, she interviewed Respondent for two hours, during which Respondent provided "tangential responses," failed to retain information that was presented to her, and "lost track of the point of her comments . . . ." Respondent denied having any practice issues at YRMC. Ms. Munger terminated the interview and scheduled a second interview "due to [Respondent's] lengthy responses and [the] frequent need to redirect her."

44. On February 16, 2009 (a state holiday) and February 17, 2009, Respondent left five lengthy voicemail messages for Ms. Munger, asking to delay the second interview until Respondent could obtain and review her employment records.

45. On February 26, 2009, Ms. Munger conducted a second interview of Respondent for another hour, with another Board employee present as a witness. Respondent also spent an hour reviewing the Board's file. Respondent maintained that she was "a good nurse," and that any problems at YRMC were the result of personality conflicts based on race. After the second interview, Respondent continued to leave voicemail messages and sent via facsimile 37 pages of documents that had previously been provided to the Board.

[1] Ms. Munger had retired by the time of the hearing and did not testify.

46. Among the documents that Respondent provided was her letter dated June 29, 2006, to her former employer, Health South/Yuma Rehabilitation Center, with the following proposal:

> I propose that this institution utilize my expertise in wound care to establish protocols for a wound team, assessment of incoming patient integumentary [sic] system with treatment, within my scope of practice, and reassessment, discharge planning, infection control, maintaining supplies for treatment, educating peers at all levels for assessment/ treatment/prevention/recording, and being the liaison among disciplines and resources. I propose utilizing the tech and/or nurse for preparing the patient for the aforementioned assessment/treatment, therefore, taking advantage of the opportunity to educate both staff and patients. . . .

47. Ms. Smith testified that the evidence showed Respondent had four problems that affected her safety to practice: (1) Limited general nursing knowledge, such as the effect of particular medications and when to bring patient issues to other providers' attention; (2) Communication with supervisors and other staff; (3) Difficulty setting priorities and time management; and (4) Lack of accountability. Because Respondent persistently refused to acknowledge any cause for concern, it did not appear that she could be regulated.

Case No. 10-0912145

48. On November 30, 2009, YPD Officer Olea responded to a 911 call from Respondent's neighbor, Maria Guadalupe ("Lupe") Roman, who reported that she had entered Respondent's house and found Respondent in the bedroom, with blood all over the bed. Ms. Roman explained that she had a key to Respondent's house because she sometimes checked on Respondent's two cats or paid the gardener for Respondent. Ms. Roman told Officer Olea that there were no weapons in Respondent's house.

49. Respondent had a hematoma on the left side of her face. Respondent initially said that she did not know what had happened, but then said that she had fallen, hit her head on a sandstone table in the living room, and gone to her bedroom to lie down. Respondent told Officer Olea that she had been throwing up and having nosebleeds. Officer Olea testified that Respondent's account appeared to

be consistent with her apparent injury. Officer Olea called the Fire Department Rural Metro to transport Respondent to the hospital.

50. On November 30, 2009, Respondent was admitted to the emergency room at YRMC. Tests performed on admission showed no indication that Respondent had been bleeding from any orifice.

51. During the initial assessment at YRMC, a CT scan was taken of Respondent's head. The radiologist who read the scan noted metal fragments in the right temporal and mandibular region of Respondent's jaw and concluded that the fragments were "consistent with relatively acute gunshot wound . . . ."

52. YRMC contacted Officer Olea and informed him that the CT scan showed bullet fragments in Respondent's brain. Officer Olea confronted Respondent with this information at YRMC, and she responded that she knew he would respect her privacy under HIPPA. Respondent never admitted to Officer Olea that she had shot herself, although she did admit that she had a small caliber gun at her house.

53. Officer Olea gave the information to his sergeant, and YPD decided to "conduct a Title 36[2]," because it appeared that Respondent had attempted suicide and was a danger to herself.

54. Officer Olea returned to Respondent's house. Ms. Roman used her key to let him in. At Respondent's house, Officer Olea collected a firearm, with one spent slug casing and four slugs in the chamber, including one slug that was hit but did not discharge. Officer Olea also collected a bloody pillow, with a hole through it and gunshot residue on one side, that appeared to have been used either to

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[2] *See* A.R.S. § 36-520(A). That statute provides in relevant part as follows:

> Any responsible individual may apply for a court-ordered evaluation of a person who is alleged to be, as a result of a mental disorder, a danger to self or to others, persistent or acutely disabled, or gravely disabled and who is unwilling or unable to undergo a voluntary evaluation. . . .

If as a result of the evaluation, two physicians submit affidavits that "the patient is in need of a period of treatment because the patient, as a result of a mental disorder, is a danger to self or to others, {and} is persistently or acutely disabled or is gravely disabled," the court may order treatment. *See* A.R.S. §§ 36-533(A); 36-540(A).

muffle the sound of a gunshot or to protect Respondent's face from the muzzle flash that results from firing a gun.

55. Officer Olea interviewed Respondent's friend Debbie Berning. Ms. Berning said that on November 26, 2009, Respondent was supposed to have Thanksgiving dinner at Ms. Berning's house. Ms. Berning said that Respondent called her on November 26, 2009, "crying uncontrollably," and that Ms. Berning ended the telephone call because she could not understand what Respondent was trying to say. Ms. Berning said that Respondent later called back when she was calmer, and said that she had had an argument with her daughter over some ongoing family issues. Respondent said that she did not want to attend Thanksgiving dinner because she wanted to be alone.

56. Officer Olea also interviewed Ms. Roman. Ms. Roman said that when she found Respondent, Respondent had left the back door ajar and had left a large quantify of cat food in the dishes for her two cats. Ms. Roman said that Respondent usually did not leave the door open for the cats and usually did not leave excessive cat food out because she was concerned about rodents.

57. Ms. Roman also told Officer Olea that before she called 911, she had gone to Respondent's house several times. Respondent told her to go away and come back later.

58. Officer Olea concluded that Respondent had shot herself and that she thought that she would die as a result.

59. Although Ms. Roman did not initially believe that Respondent had shot herself, she changed her mind when she saw more evidence. Ms. Roman later told Ms. Hill that Respondent drank too much and that her mood changed when she was drunk. Ms. Berning also told Ms. Hill that Respondent "drinks a lot."

60. Because YRMC does not have facilities to treat neurological injuries, on December 1, 2009, Respondent was air-lifted to St. Joseph's Hospital and Medical Center ("St. Joseph's") in Phoenix, Arizona.

61. On December 1, 2009, Dr. Kaplan, a psychiatrist at St. Joseph's, evaluated Respondent. Respondent denied remembering shooting herself in the head and questioned whether the wound was self-inflicted. Dr. Kaplan diagnosed Respondent as bipolar and opined that Respondent either deliberately shot herself in the head as a suicide attempt secondary to mental illness or deliberately shot herself in the head while under the influence of Ambien and alcohol.

62. Dr. Gargulo also treated Respondent at St. Joseph's. Dr. Gargulo noted that Respondent's liver enzymes were elevated and that she had a history of seizures. Dr. Gargulo diagnosed Respondent with chronic alcohol abuse and placed her on alcohol withdrawal protocol.

63. On December 9, 2009, Respondent was transferred to Connections AZ, Inc. (Magellan) Behavioral Health Services for ongoing treatment following a suicide attempt. On December 10, 2009, Respondent was discharged to Desert Vista Behavioral Health Center ("DVBHC"), which is part of MIHS, for further stabilization of mental health issues.

64. On December 10, 2009, Respondent refused offers of inpatient psychiatric treatment, stating that she would like to go home and return to work. Because Respondent refused to submit to voluntary psychiatric treatment, on December 10, 2009, DVBHC staff petitioned Respondent for court-ordered treatment.

65. On December 11, 2009, the court granted the petition, and Respondent was court-ordered for treatment at DVBHC. On December 16, 2009, DVBHC discharged Respondent so that she could be admitted to a facility in Yuma. On the discharge summary, Dr. Traci Wherry recommended

that Respondent receive further assessment, medication management, substance abuse counseling, and individual counseling, and noted that Respondent needed further monitoring for paranoia.

66. On December 16, 2009, Respondent was admitted for treatment at SMMHC in Yuma.

67. Dr. Vines testified that he evaluated Respondent on December 17, 2009. He remembered Respondent because she was an R.N. who was admitted to SMMHC for court-ordered treatment. He never before had provided court-ordered treatment for an R.N.

68. Dr. Vines testified that Respondent was "generally appropriate" during his evaluation and was "bending over backwards" to show that she did not require treatment. Respondent denied shooting herself but could not explain how the metal fragments came to be in her head. Dr. Vines testified that Respondent was "circumstantial and vague" in the interview.

69. On December 22, 2009, treating psychiatrists Dr. Krasavic and Dr. Pell opined that Respondent no longer required court-ordered treatment. The petition was suspended and Respondent was discharged to home.

70. As part of the Board's investigation, Ms. Hill interviewed Respondent's daughter, Emily Baumgart, and son, William Violette. Mrs. Baumgart told Ms. Hill that she believed that her mother had been drinking before the argument on Thanksgiving 2009. After the argument, Mr. Violette attempted to contact Respondent, without success. Mrs. Baumgart stated that Respondent was "a negative person, always tend[ed] to be the victim and never [took] responsibility for her actions." Mrs. Baumgart flew to St. Joseph's from Germany when she heard that her mother had attempted suicide, but her mother did not want her to be involved. Mr. Violette stated that Respondent had ongoing financial problems because she was a "big spender" and "addicted to shopping," and that she had lost her home to foreclosure. According to Mr. Violette, Respondent had spent the last ten years alone and

isolated, sharing her life with only her cats. According to Mr. Violette, Respondent had been an alcoholic for many years, drinking vodka and grapefruit juice, but would not admit her alcoholism.

71. In January 2010, Mrs. Baumgart and Mr. Violette filed a second petition for court-ordered treatment for Respondent.

72. On January 19, 2010, Respondent was ordered to undergo her second court-ordered treatment at SMMHC pursuant to the second petition.

73. Nurse Practitioner Judy Yurgel was Respondent's primary care provider at SMMHC. Ms. Yurgel noted that Respondent fabricated reactions to avoid taking medications. Respondent eventually accepted the mood stabilizer Abilify, and derived some good effect. Before Respondent started taking Abilify, she was haughty, demanding, disruptive, condescending, demeaning, and sarcastic on the unit. She was "hypersensitive to perceived criticism." According to Dr. Vines, Respondent "tried to be the head nurse" and was "absolutely resistant" to her own treatment. Staff had to redirect Respondent to prevent her from intruding on other patients' care by inciting them to question their care.

74. Drs. Vines, Krasavic, and Pell evaluated Respondent at SMMHC. Dr. Vines testified that in his opinion Respondent had an Axis II personality disorder, based on the way she interacted with staff and other patients on the SMMHC unit.

75. Dr. Vines testified that Respondent admitted to him, Dr. Krasavic, Dr. Pell, and Ms. Yurgel that before the court-ordered treatment, she drank one to two drinks twice a week. In Dr. Vines' opinion, Respondent's report was not accurate because people generally report less than their actual alcohol consumption. Dr. Vines assumed that Respondent was drinking more.

76. Dr. Vines testified that he believed Respondent had a mood disorder not otherwise specified, possibly depression of bipolar disorder. Dr. Vines testified that Respondent also suffered

from alcohol abuse, which in his opinion led to the shooting. Dr. Vines testified that Drs. Krasavic's and Pell's diagnoses were consistent, and that they agreed that Respondent was acutely disabled and unwilling or unable to seek appropriate treatment.

77. Dr. Vines testified that Respondent has limited insight into her condition. Respondent does not fully understand her need for treatment and does not appear to be amenable to treatment. Dr. Vines testified that Respondent's mood disorder seems to be responding to treatment, but her personality disorder is not controlled. Her alcohol abuse is a "wild card." Dr. Vines testified that he is concerned about Respondent's ability to care for patients as a nurse.

78. On February 5, 2010, Respondent was discharged from SMMHC inpatient services with recommendations to continue antipsychotic medications and Abilify, and to obtain chemical dependency treatment.

79. On February 10, 2010, Respondent began court-ordered outpatient treatment at SMMHC.

80. The court's order for out-patient treatment expired in July 2010. Respondent is no longer required to undergo treatment for her diagnosed mental illness.

81. On July 27, 2010, Ms. Richard interviewed Respondent. Ms. Richard testified that Respondent denied that she had shot herself and acted amused by others' concerns about the incident. Respondent frequently "burst into laughter" and showed an "inappropriate affect" throughout the interview.

82. On August 11, 2010, Respondent had her last recorded treatment at SMMHC. Dr. Stumpf's note for the visit states that Respondent's condition was "worsening."

83. Ms. Hill testified that her last contact with Respondent was on September 3, 2010, when Respondent stated that she was in rehabilitation from shoulder surgery and that she wanted to pursue

her nursing career. Ms. Hill testified that she is concerned about Respondent's safety to practice because Respondent continues to deny mental health or substance abuse issues that require treatment and make her unstable. There is no evidence that Respondent is getting treatment for her mental illness or substance abuse.

84. Ms. Smith testified that Respondent has undergone two court-ordered treatments, but still lacks insight into her mental condition. Courts seldom order treatment for persons of "professional caliber." Although numerous persons have reported that Respondent drinks excessively, she continues to deny that she has a problem with alcohol. Ms. Smith testified that Respondent behaved "grandiosely" during her court-ordered inpatient treatment at SMMHC, when she told other patients not to take their medications, even though they were very ill. This same grandiosity was reflected in Respondent's communications with the Board, when she provided a copy of her letter to Health South/Yuma Rehabilitation Center, proposing to start and lead a wound care unit, even though months later she had basic practice issues at YRMC.

85. Ms. Smith testified that Respondent's disease is not amenable to treatment, and her condition appears to be getting worse. Ms. Smith testified that Respondent is not safe to practice.

CONCLUSIONS OF LAW

1. This matter lies within the Board's jurisdiction under A.R.S. § 32-1606(A)(8).

2. The Complaint and Notice of Hearing and Amended Complaint and Notice of Hearing that the Board mailed to Respondent at her address of record were reasonable, and it appears that she actually received notice of the hearing.[3]

[3] See A.R.S. §§ 41-1092.04; 41-1092.05(D)

3. The Board bears the burden of proof and must establish cause to penalize Respondent's registered nurse's license by a preponderance of the evidence.[4]

4. "A preponderance of the evidence is such proof as convinces the trier of fact that the contention is more probably true than not."[5] A preponderance of the evidence is "evidence which is of greater weight or more convincing than evidence which is offered in opposition to it; that is, evidence which as a whole shows that the fact sought to be proved is more probable than not."[6]

5. The Board established that while Respondent was employed by YRMC between January 10, 2007, and May 24, 2007, she committed numerous acts of unprofessional conduct as defined by A.R.S. §§ 32-1601(16)(d) and -1601(16)(j) (effective May 9, 2002),[7] specifically A.A.C. R4-19-403(B)(1), (7), and (31) (effective November 12, 2005).[8]

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[4] See A.R.S. § 41-1092.07(G)(2); A.A.C. R2-19-119(A) and (B)(1); see also Vazanno v. Superior Court, 74 Ariz. 369, 372, 249 P.2d 837 (1952).

[5] Morris K. Udall, ARIZONA LAW OF EVIDENCE § 5 (1960)

[6] BLACK'S LAW DICTIONARY at page 1120 (8th ed. 2004)

[7] These statutory subsections define "unprofessional conduct" to include, respectively, "[a]ny conduct or practice that is or might be harmful or dangerous to the health of a patient or the public" and "[v]iolating a rule that is adopted by the board pursuant to this chapter."

[8] This rule further defines "unprofessional conduct" to include the following:

1. A pattern of failure to maintain minimum standards of acceptable and prevailing nursing practice;

7. Failing to maintain for a patient record that accurately reflects the nursing assessment, care, treatment, and other nursing services provided to the patient; [or]

31. Practicing in any other manner that gives the Board reasonable cause to believe the health of a patient or the public may be harmed.

6. The Board also established that Respondent committed an act of unprofessional practice as defined by A.R.S. § 32-1601(16)(j), specifically A.A.C. R4-19-403(B)(27)[9] when she stated that her license had not ever been investigated on her application for employment to ANM O'Grady Peyton Healthcare.

7. The Board also established that Respondent's conduct before and during the two involuntary court-ordered treatments at SMMHC demonstrated unprofessional conduct as defined by A.R.S. § 32-1601(16)(d), (e),[10] and (j), specifically A.A.C. R4-19-403(B)(17).[11]

8. Therefore, the Board established cause to revoke, suspend, or otherwise discipline Respondent's license under A.R.S. §§ 32-1663(D)[12] and -1664(N).[13] Respondent's failure to attend the hearing or to take responsibility for the unprofessional conduct that the Board established at hearing indicates that at this time she cannot be regulated.

[9] This rule further defines unprofessional conduct to include "[m]aking a false or misleading statement on a nursing or health care related employment or credential application concerning previous employment, employment experience, education, or credentials.".

[10] This statutory subsection defines "unprofessional conduct" to include "[b]eing mentally incompetent or physically unsafe to a degree that is or might be harmful or dangerous to the health of a patient or the public."

[11] This rule further defines "unprofessional conduct" to include "[a] pattern of using or being under the influence of alcohol, drugs, or a similar substance to the extent that judgment may be impaired and nursing practice detrimentally affected . . . ."

[12] This statute provides that if the Board determines a licensee has committed an act of unprofessional conduct, the Board may revoke or suspend the license, impose a civil penalty, censure the license, place the licensee on probation, or accept the voluntary surrender of the license.

[13] This statute provides that if the Board finds that the licensee has committed an act of unprofessional conduct, the Board may revoke or suspend the license.

ORDER

In view of the Findings of Fact and Conclusions of Law, the Board issues the following Order:

Pursuant to A.R.S. § 32-1664(N), the Board **REVOKES** registered nurse license number RN114470 issued to Deborah C. Haines.

RIGHT TO PETITION FOR REHEARING OR REVIEW

Pursuant to A.R.S. § 41-1092.09, Respondent may file, in writing, a motion for rehearing or review within 30 days after service of this decision with the Arizona State Board of Nursing. The motion for rehearing or review shall be made to the attention of Vicky Driver, Arizona State Board of Nursing, 4747 North 7th Street Ste 200, Phoenix AZ 85014-3655, and must set forth legally sufficient reasons for granting a rehearing. A.A.C. R4-19-608.

For answers to questions regarding a rehearing, contact Vicky Driver at (602) 771-7852. Pursuant to A.R.S. § 41-1092.09(B), if Respondent fails to file a motion for rehearing or review within 30 days after service of this decision, Respondent shall be prohibited from seeking judicial review of this decision.

This decision is effective upon expiration of the time for filing a request for rehearing or review, or upon denial of such request, whichever is later, as mandated in A.A.C. R4-19-609.

Respondent may apply for reinstatement of the said license pursuant to A.A.C. R4-19-404 after a period of five years.

DATED this 29th day of November, 2010.

ARIZONA STATE BOARD OF NURSING

SEAL

Joey Ridenour RN MN Faan

Joey Ridenour, R.N., M.N., F.A.A.N
Executive Director

COPIES mailed this 3rd day of December, 2010, by Certified Mail No. 7009 0080 0000 0433 3735 and First Class Mail to:

Deborah C. Haines
PO Box 25877
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COPIES of the foregoing mailed this 3rd day of December, 2010, to:

Case Management
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1400 W Washington Ste 101
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Emma Lehner Mamaluy
Assistant Attorney General
1275 W Washington LES Section
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By: Vicky Driver